

MDR Tracking Number: M5-04-1605-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-16-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The myofascial release, therapeutic exercises, electrical stimulation, whirlpool, iontophoresis, supplies, office visits, and massage therapy from 5/21/03 through 6/25/03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 5/21/03 through 6/25/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 29th day of April 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

April 22, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter**

**RE: MDR Tracking #: M5-04-1605-01
IRO Certificate #: 5348**

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 49 year-old male who sustained a work related injury on ___. The patient reported that while at work, he fell from a ladder injuring his right foot. On 2/5/03 the patient underwent a closed reduction of the right calcaneus fracture under C-frame control with casting. Postoperatively the patient was treated with physical therapy consisting of myofascial release, electrical stimulation, whirlpool, iontophoresis, massage therapy and therapeutic exercises.

Requested Services

Myofascial release, therapeutic exercises, electrical stimulation, whirlpool, iontophoresis, supplies, office visits, massage therapy from 5/21/03 through 6/25/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 49 year-old male who sustained a work related injury to his right ankle. The ___ physician reviewer indicated that the patient had

sustained a right ankle fracture. The ____ physician reviewer noted that the patient underwent a closed reduction and received physical therapy from 4/8/03 through 6/25/03 for right ankle range of motion, to decrease edema and pain, and increase strength. The ____ physician reviewer indicated that the records provided show that there was a good improvement in range of motion in the right ankle from 4/8/03 through 6/4/03, although the right ankle range of motion still was not within normal limits and had not plateaued. The ____ physician reviewer noted that the patient's pain had decreased and that he continued to make gains in the right ankle range of motion between 6/4/03 through 6/25/03. The ____ physician reviewer indicated that the patient's condition had not plateaued until almost 6/25/03. The ____ physician reviewer explained that the patient underwent an orthopedic evaluation and recommended for further physical therapy. The ____ physician reviewer also explained that the patient was receiving skilled services in the application of iontophoresis, whirlpool, manual stretching, his pain level was reduced to 2/10, and that his range of motion had improved to near normal. Therefore, the ____ physician consultant concluded that the myofascial release, therapeutic exercises, electrical stimulation, whirlpool, iontophoresis, supplies, office visits, massage therapy from 5/21/03 through 6/25/03 were medically necessary to treat this patient's condition.

Sincerely,